MaineCare
Health Care for Maine People

State of Maine Department of Health and Human Services

Return to:

Dept. of Health and
Human Services
OIAS Unit
13 Prescott Drive
Machias, Maine 04654

Received_____

Application For MaineCare Limited Benefits

1. Person Applying

Your name (first, middle initial, last)		
Social Security Number	Birthdate (month/day/year)	Sex

2. Mailing Address

Street, PO Box, or RR (include apartment number, in care of, etc.)			
City	State	Zip Code	Phone
If different from your mailing address, give the address where you actually live:			

3. Household Members *List the people who live with you*

Last name	First name	Sex	Birthdate	Relationship to you	Is this person applying for benefits?	Social Security number for those applying

4. Income (Part A) Attach paystubs or photocopies of paystubs for the last 4 weeks

A. Self-Employment

Name of person who is self-employed:	Name of business:
List business income from the most recent federal tax return: Form 1040, line 12 _____	
If you did not file a tax return, what is your yearly income from self-employment (minus business expenses)_____	

4. Income (Part B) *Answer only for people applying*

B. List all gross income (before taxes) received. This includes income from wages and from other sources such as child support, Unemployment Compensation, interest income, Social Security, Workers Compensation.

Name of person with income	Source of income (Employment, child support, etc.)	How often received? (Weekly, bi-weekly, monthly, bi-monthly, etc.)	Amount Received
1.			
2.			
3.			
4.			

5. Citizenship *Answer only for people applying*

Are all the people who are applying U.S. citizens? Yes ☐ No ☐
If no, list their names and Alien Registration Numbers. This is on the back of the I-94 card.

Name	Alien Registration Number

6. Help with Applying

If you have a guardian, conservator or someone who knows your situation, and you would like us to contact them to help with this application, please complete the following:

Name _____ Telephone _____

Address _____

I understand the questions on this form and that this application is voluntary. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know.

Signature of person applying _____ Date _____

Signature of person filling out this form _____ Date _____

Social Security numbers are used to do computer matches with I.R.S., the Social Security Administration, Department of Labor, other government agencies and private financial institutions. The Department of Human Services and federal officials may verify any information given.

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MaineCare Benefit For People Living With HIV/AIDS
Informed Consent Form

To get the MaineCare Benefit for People Living with HIV/AIDS, you must read this form carefully and sign it. This form tells you what you must know about this Benefit. By reading and signing this form, you let us know that you understand and want to get this Benefit.

1. No one is making me participate. This is something I want to do. In order to get services under this Benefit I must:
    a. be medically and financially eligible;
    b. follow the treatment plan recommended by my doctor;
    c. take the medications the doctor has prescribed;
    d. keep my appointments with the doctor and the laboratory; and
    e. pay any monthly premiums and the Benefit co-payments. The amount of the premium will change over time.
2. I know there is a limit to the number of people who can get this Benefit. If the limit is reached, I will be put on a waiting list. Names will be listed on a first come, first served basis. I will get a letter when there is an opening.

Other things I need to know:
The MaineCare Benefit for People Living with HIV/AIDS is not the same as MaineCare Full Benefits.

On the next page, there is a list of services this MaineCare Benefit For People Living With HIV/AIDS will cover and services it will not cover.

If you become eligible for MaineCare Full Benefits while getting the MaineCare Benefit for People Living with HIV/AIDS, we will add those benefits to your care coverage.

Signed,

_____

Signature

_____ _____

Printed Name Date

Please sign and return this page to the Bureau of Family Independence in the envelope provided.
If you have questions about this form please call 1-866-796-2463.
You may keep the list of covered and non-covered services for your records.

MaineCare
Benefit for People Living With HIV/AIDS

1. Covered Services

MaineCare will pay for the following services for members receiving the Benefit forPeople Living with HIV/AIDS.

- Medications
- Physicians including those at Federally Qualified Health Clinics (FQHCs) and Rural Health Clinics (RHCs)
- Physician Assistants
- Advance Practice Registered Nurses
- Ambulance
- Transportation to covered services
- Behavioral Health Services
- Substance Abuse Services
- Case management
- Hospital
- VD (STD) Clinic Services
- Ambulatory Surgical Centers
- Family Planning Agency Services
- Lab and X-ray Services
- Ambulatory Care Clinics
- Early Intervention Services

2. Non-Covered Services

Members receiving the Benefit for People Living with HIV/AIDS do not get MaineCare Full Benefits. They only get the services identified in # 1 above. Examples of services not covered include:

- Chiropractic Services
- Dental Services
- Vision Services
- Hospice Services
- Medical Supplies and Durable Medical Equipment
- Physical and Occupational Therapy
- Speech Therapy
- Private Non-Medical Institution Services
- Hearing Aids and Audiology Services
- Nursing Facility Services
- Home and Community Benefits

If you have questions about benefits, please call MaineCare at 1-866-796-2463.

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CONSENT TO DISCLOSURE OF HIV TEST RESULTS TO THE DEPARTMENT OF HUMAN SERVICES

I, _____ authorize
(test subject)

_____
(person or office making the disclosure)

to disclose the results of an HIV test done on me to:

The Department of Human Services, including the Bureau of Health, Bureau of Medical Services and the Bureau of Family Independence, including but not limited to, all employees who are caseworkers or supervisors, and who work in regional administration, quality control, the Department's central office, audit office, and hearing's unit. In addition, test results may be disclosed to employees of the Federal Department of Health and Human Services who perform audit and review functions for the federally funded benefit programs.

Disclosure to those listed in the above paragraph, of the results of the HIV test performed on me is specifically limited to the purpose of determining my eligibility for any or all of the following benefits: Temporary Assistance to Needy Families (TANF); Medicaid, including HIV Waiver programs; Food Stamps; Emergency Assistance; ASPIRE; or Family Services.

DATE_____

SIGNATURE_____

SIGNATURE OF PARENT OR GUARDIAN (where required):

_____

SIGNATURE OF AUTHORIZED PERSON (where required):

_____

This consent can be revoked, in writing, showing authorized signature and the date, at any time except to the extent that the person or office disclosing test results has already taken action in reliance upon this consent. If not previously revoked, this consent will expire one year after it's execution.

D.O. Code _____

THIRD PARTY RESOURCE INFORMATION REQUEST

[ ] New App [ ] Review [ ] Change/Cancellation [ ] TANF [ ] Medicaid

Case Name: _____ Case ID# _____ Tel.# _____

Household Members	Medicaid ID#	DOB	Sex
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___

1. Are you or anyone in the household covered by any health insurance other than Medicare or Medicaid? Yes ___ No ___

***************IF YES, THE FOLLOWING MUST BE COMPLETED*************

PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)

2. Name of Policyholder/Employee: _____ SS# _____

Employer's name: _____ Tel# _____
Address _____

Name of insurance company(s) _____
Address _____
_____ Tel# _____

Date policy began: _____ Date ended: _____

Group # _____ Certificate/Policy # _____

Name and address of prescription card company, if any _____
_____ Group# _____ Policy# _____

Name and address of dental insurance company, if any _____
_____ Group# _____ Policy# _____

Name and address of vision insurance company, if any _____
_____ Group# _____ Policy# _____

3. Is insurance listed above provided by an absent parent? Yes____ No____

If yes, absent parent name _____ SS# _____
Address _____
_____ Tel # _____

ACCIDENT INFORMATION (if applicable)

Name of injured person: _____

Date of accident: _____ Nature of injury _____

Attorney/insurance company name: _____
_____

RIGHTS AND RESPONSIBILITIES ON REVERSE SIDE

Signature _____ Date _____

Hints to Complete the Limited Benefits Waiver Application:

→ **Fill in every space – with words, a line, or n/a.**

→ **Main application form– point 4. Income.**
- Part A is for self-employment only.
- Part B is for other employment, but ONLY yours – not your partner.
- Only include a copy of a pay stub if you are self-employed.

→ **Main application form– point 5. Citizenship.**
- US citizens, legal aliens, refugees and asylum-seekers are eligible.
- Those whose 'papers' are processing are eligible too.

→ **Informed Consent form**
- Just sign and date.

→ **Consent to Disclose HIV Status form.**
- *Test Subject* is you.
- *Person or Office* can be your Case Manager, MD, NP, or Lynn Berry at ADAP/Maine CDC. Lynn manages the HIV database, and can process the forms with the eligibility office right electronically – FAST!

→ **Third Party Resource form.**
- Check "New Application"
- Case Name = Your Name
- Case ID can be left blank.

→ **** Be sure to complete point 1.**
- If No – sign and date the bottom of the page.
- If Yes – (Private Health Insurance)
  Be sure to fill in the rest of the page.